Patient Information & Medical History

Name: _____ Date of Birth: _____

Parent or Guardian if under 19 _____

Email: _____ Communication Preference: _____

Address: _____ City/State: _____ Zip _____

Phone: Home _____ Work _____ Cell _____ text ok? _____

Employer: _____ Occupation: _____ SSN _____ - _____ - _____

Medical Insurance: _____ Vision Insurance: _____

Medications: _____

Allergies to medications? _____ Please list:_____

Family History (circle)	Relationship
Blindness	
Glaucoma	
Lazy Eye	
Macular Degeneration	
Retinal Disease	

Pregnant or Nursing? _____ Do you use tobacco? _____

Eye surgery? _____ For what? _____

Date of last eye exam: _____ by Dr. _____

Family physician _____

Have you ever worn contact lenses? _____Are you interested in contact lenses? _____

Computer usage per day: _____ Hobbies? _____ Sports? _____

Review of Systems: Do you currently, or have you ever had any problems in the following areas? If yes, please explain.		
Yes/No	**System**	**Explain**
	Ear, Nose, Throat	
	Cardiovascular (eg. heart)	
	Gastrointestinal	
	Genitourinary	
	Respiratory (eg. breathing)	
	Skin	
	Bones/Joints	
	Blood	
	Endocrine (eg. diabetes)	
	Neurological (eg. headaches)	
	Psychiatric (eg. ADD)	
	Allergic	

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Patient signature: _____ Doctor's signature: _____